V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31096

Registration District No. 130 Primary Registration District No. 5572 Registrar's No. 126

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Prairie Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson County Emergency Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week (Specify whether

In this community 42 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Rural Prairie
(If outside city or town limits, write "RURAL")

(d) Street No. Lees Summitt, Mo. RGF#3
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Louis R. Spradley

3. (b) If veteran, name war No

3. (c) Social Security No. 525-12-0582

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Vera Mansfield Spradley

6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased Jan. 5, 1902
(Month) (Day) (Year)

8. AGE: Years 42 Months 8 Days 12 If less than one day hr. min.

9. Birthplace Slater Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Machanic

11. Industry or business K.C. Public Service Co.

FATHER
12. Name Clarence E Spradley
13. Birthplace Cedar City, Mo.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nellie J. Hamby
15. Birthplace Slater Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Vera Spradley

(b) Address Lees Summitt, Mo.

17. (a) Burial (b) Date thereof Sept. 19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Cemetery

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address K.C. Mo.

19. (a) Sept. 18, 1944 (b) F. M. Schick by E. M. S.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17 year 1944 hour 4 minute 30 A M.

21. I hereby certify that I attended the deceased from March 7 1944 to Sept 17 44 that I last saw him alive on Sept 16 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Sarcoma	3 mos
Due to Generalized in abdomen	6 weeks
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations No Gall Stones abdomen negative

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address [illegible] Date signed 11/18/44

1162

(Licensed Embalmer's Statement on Reverse Side)

MAY 6 1946

OCT 10 1944

OCT 5 1942

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed J. Farrell Shul

Licensed Embalmer No. 93625

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.